

**FIG. 1**

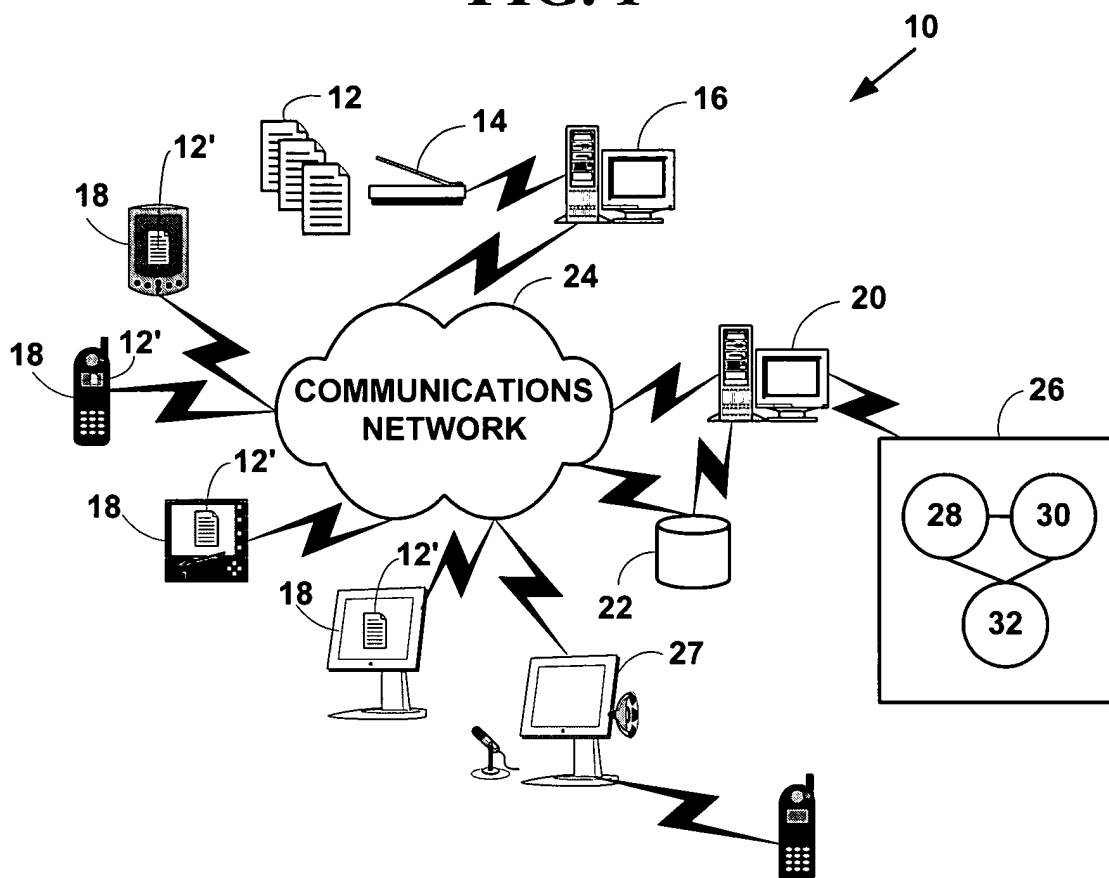


FIG. 2A

36
34

☐ Trend  
☐ Print

☐ First Name  
☐ Social Security / Patient Account Number  
☐ Today's Date (mm-dd-yy)

☐ MI  
☐ Date of Birth (mm-dd-yyyy)  
☐ Visit Time (hh-mm)

☐ Last Name  
☐ AM  
☐ PM

General PIVOT™  
Ver. 0017 08/31/03

☐ Cash  
☐ Rescan  
☐ No Code  
☐ Discard

PV TEST PRACTICE 9999  
 303A ANDREWS DR., BELVIDERE, IL 61008

**Main Problem (choose only one)**

☐ pain  
☐ numbness  
☐ swelling  
☐ other (specify)

☐ pressure  
☐ itching  
☐ congestion

☐ vomiting  
☐ diarrhea  
☐ cough

☐ nausea  
☐ anxiety/nerves  
☐ depression

Where is it? \_\_\_\_\_

For about how long? \_\_\_\_\_ hr \_\_\_\_\_ day \_\_\_\_\_ mo \_\_\_\_\_ yr

Worse when... \_\_\_\_\_

Better when... \_\_\_\_\_

It is... ☐ constant ☐ constant, worse at times ☐ comes & goes

List related symptoms... \_\_\_\_\_

How severe? (check one) 
0
1
2
3
4
5
6
7
8
9
10
(check one)      None pain or symptoms      worst of your life

Additional Description \_\_\_\_\_

Was this a result of an injury? ☐ no ☐ yes (describe below) \_\_\_\_\_

Motor vehicle accident? ☐ no ☐ yes      Work-related? ☐ no ☐ yes

**Medical Prob**

☐ None  
☐ heart disease  
☐ lung disease  
☐ diabetes  
☐ cancer (specify) \_\_\_\_\_  
☐ seizures  
☐ hay fever  
☐ high blood press

**Medications**

☐ None  


**Past Surgeries**

☐ None (surgery & date)  


**Family History: illnesses occurring before age 65**

Father ☐ none \_\_\_\_\_

Mother ☐ none \_\_\_\_\_

Siblings ☐ none \_\_\_\_\_

Children ☐ none \_\_\_\_\_

**Tobacco** ☐ never quit in (yr) \_\_\_\_\_ ☐ cigars

packs per day ☐ <1/2 ☐ <1 ☐ 1 ☐ 1 1/2 ☐ >2 ☐ chew or snuff

**Alcohol** ☐ never drinks per day ☐ <1 ☐ 1-2 ☐ 1 1/2 ☐ >2

**Illicit Drugs?** ☐ no ☐ yes patent pending © 2003 Practice Velocity

**Recent Abnormal (for you) Symptoms**

Const	<input type="checkbox"/> None	<input type="checkbox"/> stool <input type="checkbox"/> hard <input type="checkbox"/> loose <input type="checkbox"/> flat <input type="checkbox"/> weight loss
Neuro	<input type="checkbox"/>	<input type="checkbox"/> tingling <input type="checkbox"/> numbness <input type="checkbox"/> pain <input type="checkbox"/> dizziness <input type="checkbox"/> headache <input type="checkbox"/> numb <input type="checkbox"/> tingling <input type="checkbox"/> urinary <input type="checkbox"/> vision changes
Head	<input type="checkbox"/>	<input type="checkbox"/> pain in → <input type="checkbox"/> ear <input type="checkbox"/> dizziness <input type="checkbox"/> pain <input type="checkbox"/> ringing <input type="checkbox"/> ear ringing <input type="checkbox"/> nose/ear/throat <input type="checkbox"/> headache
Eyes	<input type="checkbox"/>	<input type="checkbox"/> eye irritation <input type="checkbox"/> double vision <input type="checkbox"/> eye pain
Skin	<input type="checkbox"/>	<input type="checkbox"/> rash/itch <input type="checkbox"/> hives <input type="checkbox"/> dry skin
Musc-Skel	<input type="checkbox"/>	<input type="checkbox"/> muscle pain → <input type="checkbox"/> weakness <input type="checkbox"/> muscle aches <input type="checkbox"/> joint pain → <input type="checkbox"/> stiffness <input type="checkbox"/> bone aches
Cardio	<input type="checkbox"/>	<input type="checkbox"/> chest pain/pressure <input type="checkbox"/> heart flutter <input type="checkbox"/> palpitations <input type="checkbox"/> fluttering motion <input type="checkbox"/> swelling of legs or feet
Resp	<input type="checkbox"/>	<input type="checkbox"/> shortness of breath <input type="checkbox"/> cough <input type="checkbox"/> wheezing
G.I.	<input type="checkbox"/>	<input type="checkbox"/> belly pain <input type="checkbox"/> diarrhea <input type="checkbox"/> nausea <input type="checkbox"/> vomiting
Genito-Urinary	<input type="checkbox"/>	<input type="checkbox"/> painful or frequent urination <input type="checkbox"/> waking up to urinate <input type="checkbox"/> sexual dysfunction <input type="checkbox"/> itching <input type="checkbox"/> pain <input type="checkbox"/> discharge <input type="checkbox"/> irregular periods
Endo	<input type="checkbox"/>	<input type="checkbox"/> extreme thirst <input type="checkbox"/> extreme hunger <input type="checkbox"/> excessive sweating <input type="checkbox"/> excessive dryness
Psych	<input type="checkbox"/>	<input type="checkbox"/> depressed or sad <input type="checkbox"/> nervous <input type="checkbox"/> difficulty sleeping
Heme	<input type="checkbox"/>	<input type="checkbox"/> glandular swelling <input type="checkbox"/> unusual bleeding
Allergy	<input type="checkbox"/>	<input type="checkbox"/> itchy eyes <input type="checkbox"/> sneezing <input type="checkbox"/> frequent colds

**Allergies (Document in boxes below)**

--	--	--	--

Pregnant? ☐ Yes ☐ No ☐ Unsure

Last Menses \_\_\_\_\_ (mm-dd-yy)

Last Tetanus Booster \_\_\_\_\_ (mm-dd-yy)

**Quality Verification**

Sign in Complete

→

Sign out Complete

→

PIVOT™ Scanned

0001051

36849

38

41

FIG. 2C

139 135 133

E/M-99203 History=DET (CC=COMP; HPI=COMP; PFMH=DET; ROS=DET)  
 Exam=DET (13 Bullets & Systems) / Complexity of MDW=MOD (DX=MOD; RISK=MOD; Data=N/A)

☒ New  
☐ Est  
☐ PBC  
☐ Conc  
☐ Trans  
☐ Pre-Surg  
☐ Phys  
☐ Zoph

First Name MI Last Name  
 Social Security / Patient Account Number Date of Birth (mm-dd-yyyy)  
 Today's Date (mm-dd-yy) Visit Time (hh-mm) AM PM

General PiVoT™  
 Ver 0017-08/31/03

☐ Cean  
☐ Rascan  
☐ No Code  
☐ Discard

**Main Problem (choose only one)**  
☐ pain ☐ pressure ☐ vomiting ☐ nausea  
☐ numbness ☐ itching ☐ diarrhea ☐ anxiety/nerves  
☐ swelling ☐ congestion ☒ cough ☐ depression  
☒ Other (specify) chest

Where is it? chest  
 For about how long? 04 day 00 mo 00 yr  
 Worse when... afternoon  
 Better when... pt goes to bed  
 It is... ☒ constant ☐ constant, worse at times ☐ comes & goes  
 List related symptoms: chills, productive cough, yellow sputum, tightness in chest SOB

How severe? 0 1 2 3 4 5 6 7 8 9 10  
 (check one) (none pain or symptoms) (worst of your life=10)

Additional Description  
 Was this a result of an injury? ☒ no ☐ yes (describe below)

Motor vehicle accident? ☒ no ☐ yes Work-related? ☒ no ☐ yes

**Medical Prob**  
☒ None  
☐ heart disease  
☐ lung disease  
☐ diabetes  
☐ cancer (specify)  
☐ seizures  
☐ hay fever  
☐ high blood press

**Medications**  
☐ None  
☐ OTC Tussing  
☐ Tylenol

**Past Surgeries**  
☒ None (surgery & date)

**Family History: illnesses occurring before age 65**  
 Father ☐ none  
 Mother ☐ none  
 Siblings ☐ none  
 Children ☐ none

**Tobacco** ☐ never quit in (yr) 0 0 0 0 ☐ cigars  
 packs per day ☐ <1/2 ☒ <1 ☐ 1 ☐ 1 1/2 ☐ >2 ☐ chew or snuff

**Alcohol** ☒ never drinks per day ☐ <1 ☐ 1-2 ☐ 1 1/2 ☐ >2  
☒ Illicit Drugs? ☐ no ☐ yes

**Recent Abnormal (for you) Symptoms**  
 Const ☐ fever ☒ chills ☐ sweats ☐ tired ☐ weight loss  
 Neuro ☐ headache ☐ weakness ☐ poor balance or coordination  
☐ numb ☐ tingling ☐ urinary or bowel changes  
 Head ☐ pain in ☐ ear ☐ mouth ☐ tooth ☐ throat  
☐ pain hearing ☐ nose discharge ☒ hoarse voice  
 Eyes ☐ blurred vision ☐ double vision ☐ eye pain  
 Skin ☐ insect bites ☐ rash ☐ itching  
 Musc-Skel ☐ muscle pain ☐ one area ☐ many areas  
☐ joint pain ☐ one joint ☐ several joints  
 Cardio ☐ chest pain or pressure ☐ light headed ☐ fainting  
☐ fluttering in chest ☐ swelling of legs or feet  
 Resp ☒ short of breath ☒ cough ☐ wheeze  
 G.I. ☐ belly pain ☐ diarrhea ☐ nausea ☐ vomiting  
 Genito-Urinary ☐ painful or frequent urination ☐ waking up to urinate  
☐ sexual difficulties ☐ itching ☐ pain ☐ discharge  
☐ irregular periods  
 Endo ☐ often feel cold ☐ often feel hot  
☐ overly tired ☐ overly thirsty  
 Psych ☐ depressed/feeling blue ☐ anxious ☐ difficulty sleeping  
 Home ☐ gland swelling ☐ unusual bruising  
 Allergy ☐ itchy eyes ☐ sneezing ☐ frequent infections

4 days hxs chest congestion  
cough

**Allergies (Document in boxes below)**  
NADA  
 Pregnant? ☐ Yes ☐ No ☐ Unsure  
 Last Menses 00 - 00 - 00  
 Last Tetanus Booster 00 - 00 - 00

**Quality Verification**  
0000 → 0713 → 0818  
 Sign in Complete Sign out Complete PIVoT™ Scanned

0021219 36049

FIG. 2D

137

40

First Name		MI	Last Name	Date of Birth (mm-dd-yyyy)	Gen	Px
T 9824P 78		BP	140/82	10/18/03		
VSx3		R	Wt. (lbs)	Ht.		
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>Eyes</b></p> <p><input checked="" type="checkbox"/> General appearance</p> <p><input checked="" type="checkbox"/> Conjunctivae &amp; Eyelids</p> <p><input type="checkbox"/> PERRLA (symmetrical)</p> <p><input type="checkbox"/> Ophthalmoscopy (disc sz, C/D, look, vessel, exud, bleed)</p> <p><b>ENT</b></p> <p><input checked="" type="checkbox"/> Pinnae &amp; Nose (appearance, scar, lesion, mass)</p> <p><input checked="" type="checkbox"/> Otitoscopy (TMs and ECs)</p> <p><input checked="" type="checkbox"/> Hearing (e.g., whisper, finger rub, tuning fork)</p> <p><input checked="" type="checkbox"/> Nares (mucosa, septum, turbinates)</p> <p><input checked="" type="checkbox"/> Mouth (lips, teeth, gums)</p> <p><input checked="" type="checkbox"/> Pharynx (mucosa, saliv glands, palate, tongue, tonsils, post.)</p> <p><b>Neck</b></p> <p><input checked="" type="checkbox"/> Exam (mass, appearance, symmetry, trachea, crepitus)</p> <p><input checked="" type="checkbox"/> Thyroid (enlargement, tenderness, mass)</p> <p><b>Resp</b></p> <p><input checked="" type="checkbox"/> Effort (retraction, access, muscles, diaphragm movement)</p> <p><input checked="" type="checkbox"/> Auscultation (breath sounds, crackles, rales)</p> <p><input type="checkbox"/> Percussion (dullness, flatness, hyperresonance)</p> <p><input type="checkbox"/> Palpation (eg, tactile fremitus)</p> <p><b>Cardio</b></p> <p><input type="checkbox"/> Auscultation (abnormal sounds, murmurs)</p> <p><input type="checkbox"/> Palpation (PMI location, size, thrills)</p> <p><input type="checkbox"/> Carotids (pulse amplitude, bruits)</p> <p><input type="checkbox"/> Abdominal aorta (size, bruits)</p> <p><input type="checkbox"/> Femoral arteries (pulse amplitude, bruits)</p> <p><input type="checkbox"/> Pedal pulses (pulse amplitude)</p> <p><input type="checkbox"/> Extremities (edema, varicosities)</p> <p><b>Breast</b></p> <p><input type="checkbox"/> Inspection (symmetry, nipple discharge)</p> <p><input type="checkbox"/> Palpation (include axillae: mass, lump, tender)</p> <p><b>GI/abd</b></p> <p><input type="checkbox"/> Masses or Tenderness</p> <p><input type="checkbox"/> Liver &amp; Spleen</p> <p><input type="checkbox"/> Anus, Perineum, Rectum (sph. tone, hemorrhoid, mass)</p> <p><input type="checkbox"/> Stool sample for occult blood</p> <p><input type="checkbox"/> Hernia</p> <p><b>GU</b></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>female</p> <p><input type="checkbox"/> External &amp; Vagina</p> <p><input type="checkbox"/> Urethra</p> <p><input type="checkbox"/> Bladder</p> <p><input type="checkbox"/> Cervix</p> <p><input type="checkbox"/> Uterus</p> <p><input type="checkbox"/> Adnexa &amp; Parametria</p> </div> <div style="width: 45%;"> <p>male</p> <p><input type="checkbox"/> Scrotum</p> <p><input type="checkbox"/> Penis</p> <p><input type="checkbox"/> Prostate</p> </div> </div> <p><b>Skin</b></p> <p><input type="checkbox"/> Inspection</p> <p><input type="checkbox"/> Palpation</p> <p><b>Neuro</b></p> <p><input type="checkbox"/> CN 2-12</p> <p><input type="checkbox"/> DTR's</p> <p><input type="checkbox"/> Sensation</p> <p><b>Psych</b></p> <p><input type="checkbox"/> Judgement &amp; Insight</p> <p><input type="checkbox"/> O x 3</p> <p><input type="checkbox"/> Memory (remote and recent)</p> <p><input type="checkbox"/> Mood &amp; Affect</p> <p><b>Musculo-skeletal</b></p> <p><input type="checkbox"/> Gait &amp; Station</p> <p><input type="checkbox"/> Digits: inspection &amp; palpation (clubbing / cyanosis)</p> </div> <div style="width: 50%;"> <p style="text-align: center;">41</p> <p>Core &amp; Fluid</p> <p>Neck &amp; esophagus</p> <p>Mouth with symptoms</p> <p>Neck &amp; lymph</p> <p>Core &amp; not harsh for sound</p> <p>④ Cough</p> </div> </div>						

**Diagnoses**

☐ new (w/o pending)

☒ new (w/o complete)

est ☐ recur ☐ exac

est ☐ recur ☐ exac

☐ est (stable)

☐ est (stable)

☐ est (stable)

☐ minor ☐ new/return

☐ minor (reg. w/old history, muscle/bone)

**Select 1 highest box!**

☐ life threat; chr prb (sav exac)

☐ acute neuro change (TIA, sz, weak, or fracture (manipulation))

☒ Rx mod; chr prb (mild exac)

☐ acute prb (syst. sx or compl)

☐ head injury brief LOC, 2 chronic problems, or fracture (no manipulation)

☐ OTC med; minor surg.

☐ acute problem (uncomplic.), or 1 chronic problem (stable)

☐ minor prob, rest, gargles... (eg, cold, sinus, conjunctiv, insect bite)

**In Global Period**

☐ day 1; 0-10d global

☐ day 1; 90d global

☐ day 1; sched. proc.

☐ routine flu to global

☐ complication

☐ related procedure

☐ unrelated problem

☐ previous procedure different provider

If counseling &/or coord. of care >50% of visit, list total face-to-face time & document content.

☐ >10 ☐ >15 ☐ >20 ☐ >25 ☐ >30 ☐ >40 ☐ >45 ☐ >60 ☐ >80

**FIG. 3**

42

NECK

40

48

● ☐ ☐ 44 46 EXAM (MASS, APPEARANCE, SYMMERTY, TRACHEA, CREPITUS)

● ☐ ☐ THYROID (ENLARGEMENT, TENDERNESS, MASS)

50

GREEN

RED

DIAGNOSES

41

☐ NEW (W/U PENDING)

☐ NEW (W/U COMPLETE)

EST ☐ RECUR ☐ EXAC

EST ☐ RECUR ☐ EXAC

☐ EST (STABLE)

☐ EST (STABLE)

☐ EST (STABLE)

☐ MINOR ☐ NEW/RECUR

☐ MINOR  
(e.g, cold, tinea, or insect bite)

FIG. 4

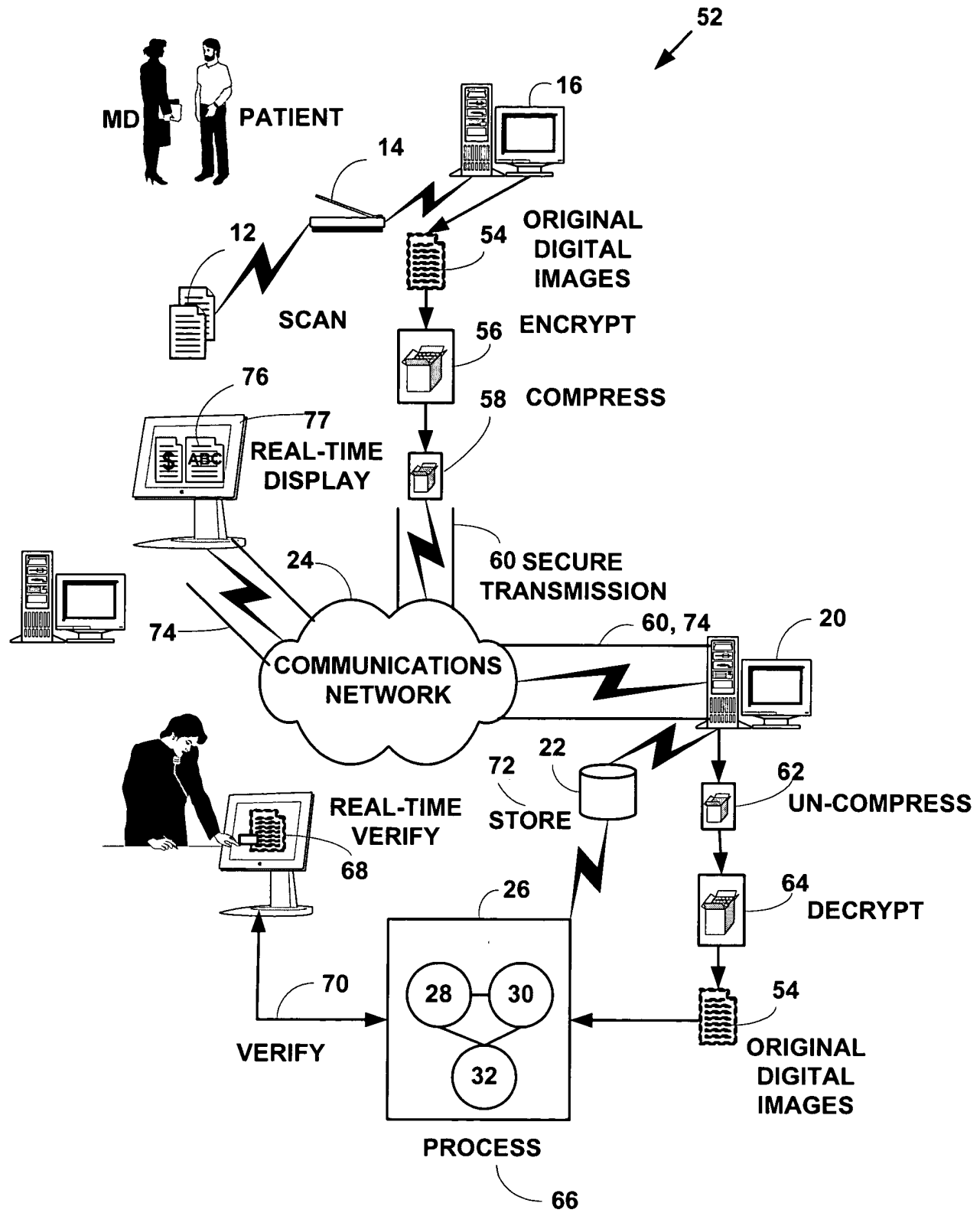
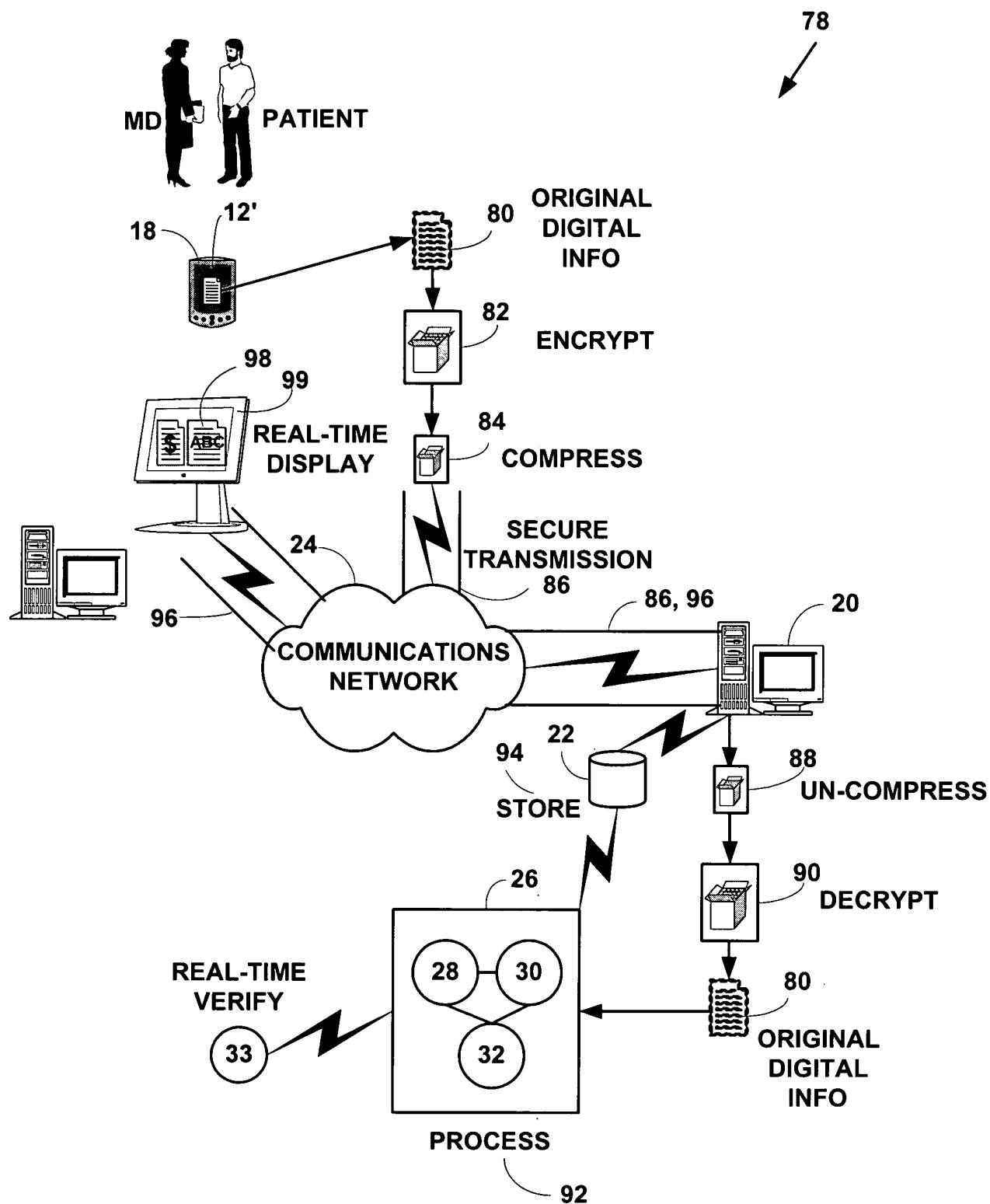
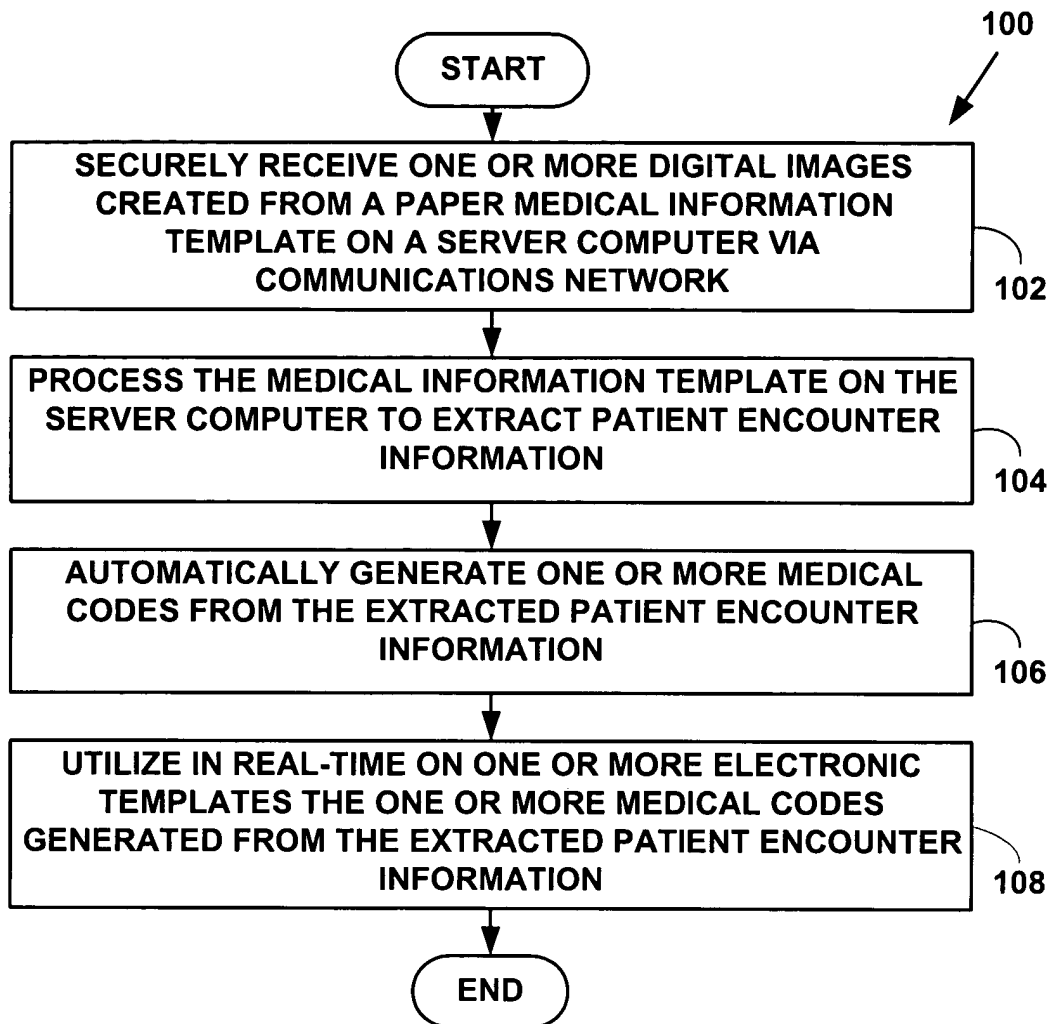


FIG. 5





**FIG. 6**



**FIG. 7**

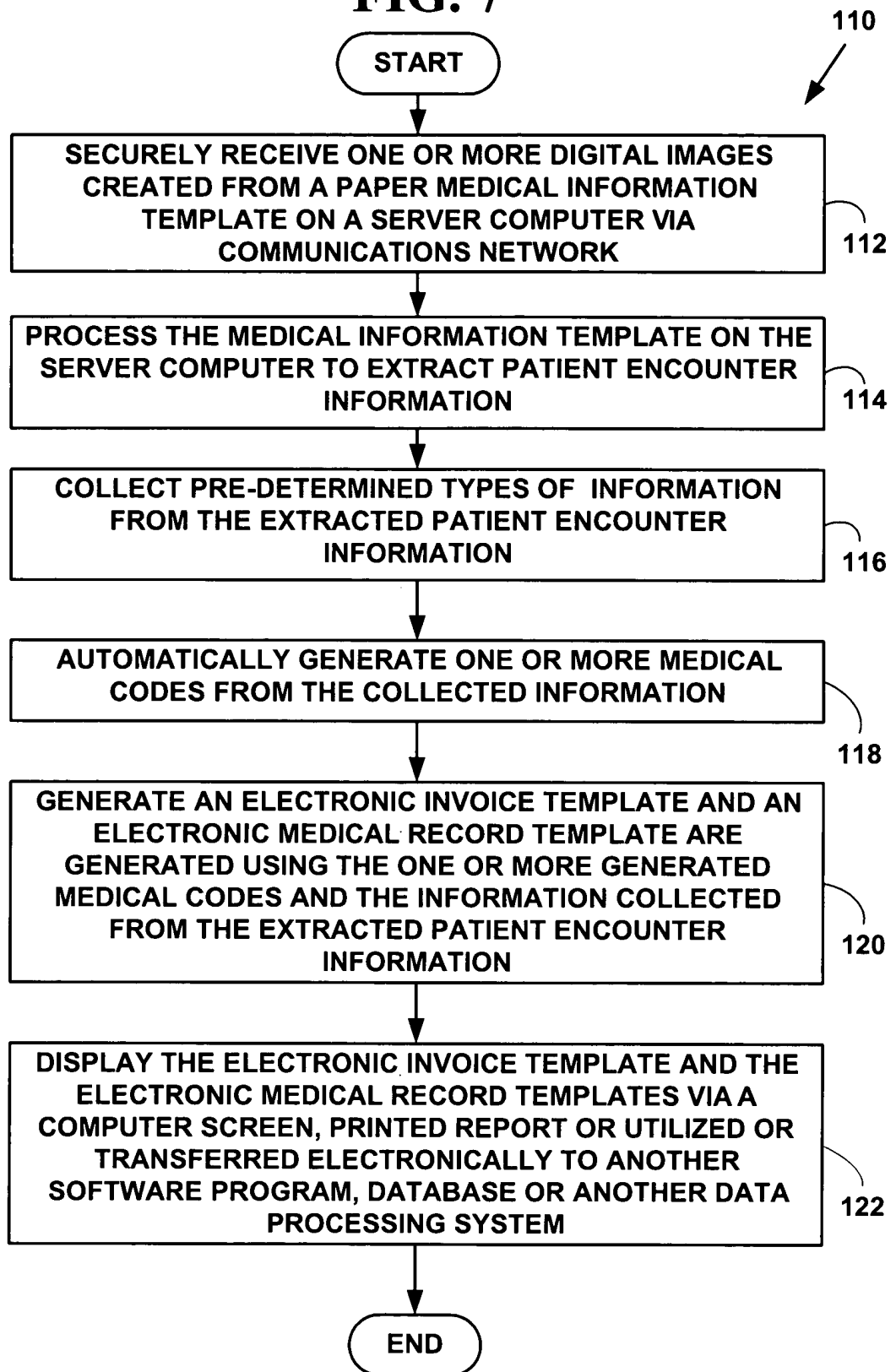



FIG. 8

**HX**  (pick lowest) 124


	<b>CC</b>	<b>HPI</b>	<b>PFMSH</b>	<b>ROS</b>
<b>PF</b>		<b>0</b>	<b>0</b>	<b>0</b>
<b>EXPF</b>		<b>1</b>	<b>1</b>	<b>1</b>
<b>DET</b>				<b>2</b>
<b>COMP</b>	<b>1</b>	<b>4</b>	<b>2,3</b>	<b>10</b>

FIG. 9

**PX** 126

<b>PF</b>	<b>1 bullet</b>
<b>EXPF</b>	<b>6 bullets</b>
<b>DET</b>	<b>12 bullets (2 systems)</b>
<b>COMP</b>	<b>≥2 bullets each in ≥9 systems</b>

FIG. 10

**CX**  (pick lowest) 128

	<b>DX</b>	<b>RISK</b>
<b>HIGH</b>	<b>4</b>	<b>4</b>
<b>MOD</b>	<b>3</b>	<b>3</b>
<b>LOW</b>	<b>2</b>	<b>2</b>
<b>SF</b>	<b>1</b>	<b>1</b>

# FIG. 11

**Final E/M** NEW OUTPATIENT

130

	99201	99202	99203	99204	99205
HX	PF	EXPF	DET	COMP	COMP
PX	PF	EXPF	DET	COMP	COMP
CX	SF	SF	LOW	MOD	HIGH

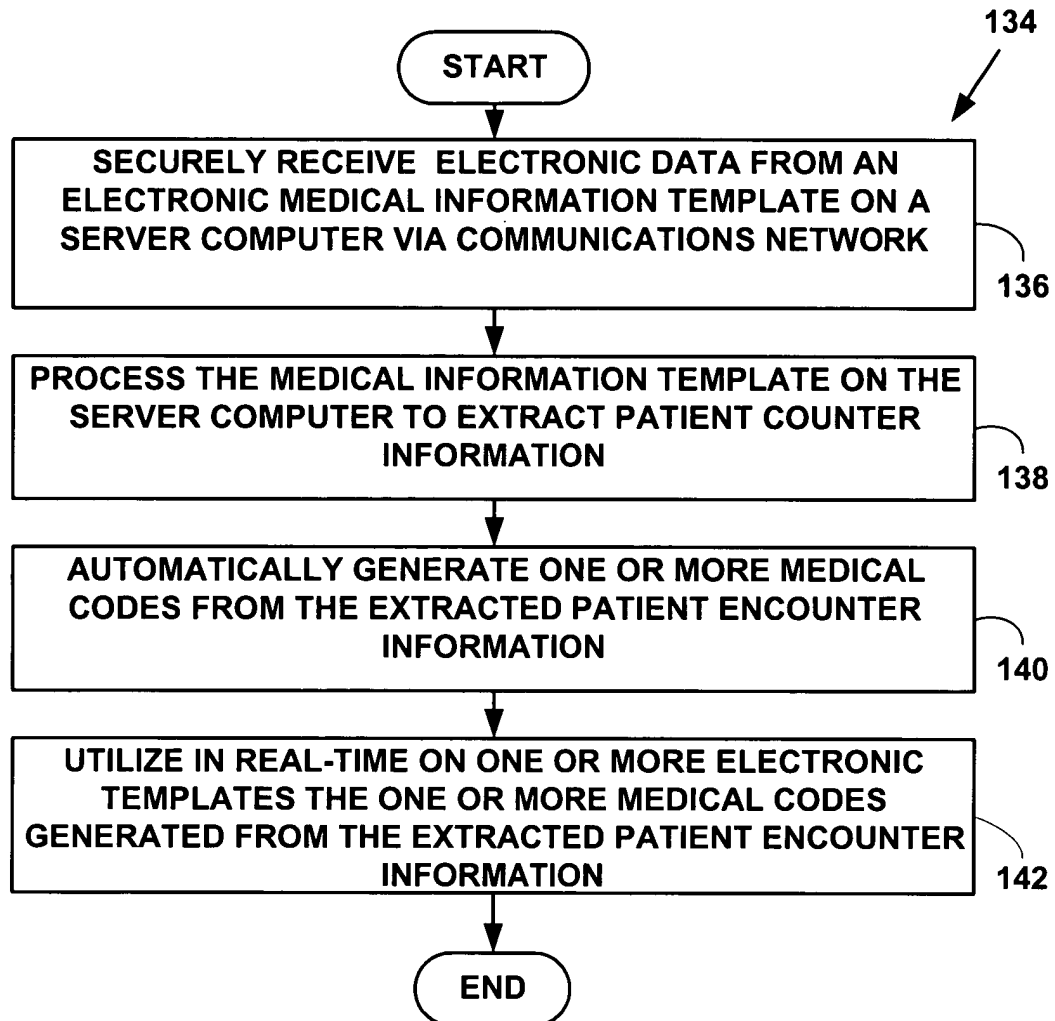
# FIG. 12

**Final E/M** ESTABLISHED OUTPATIENT

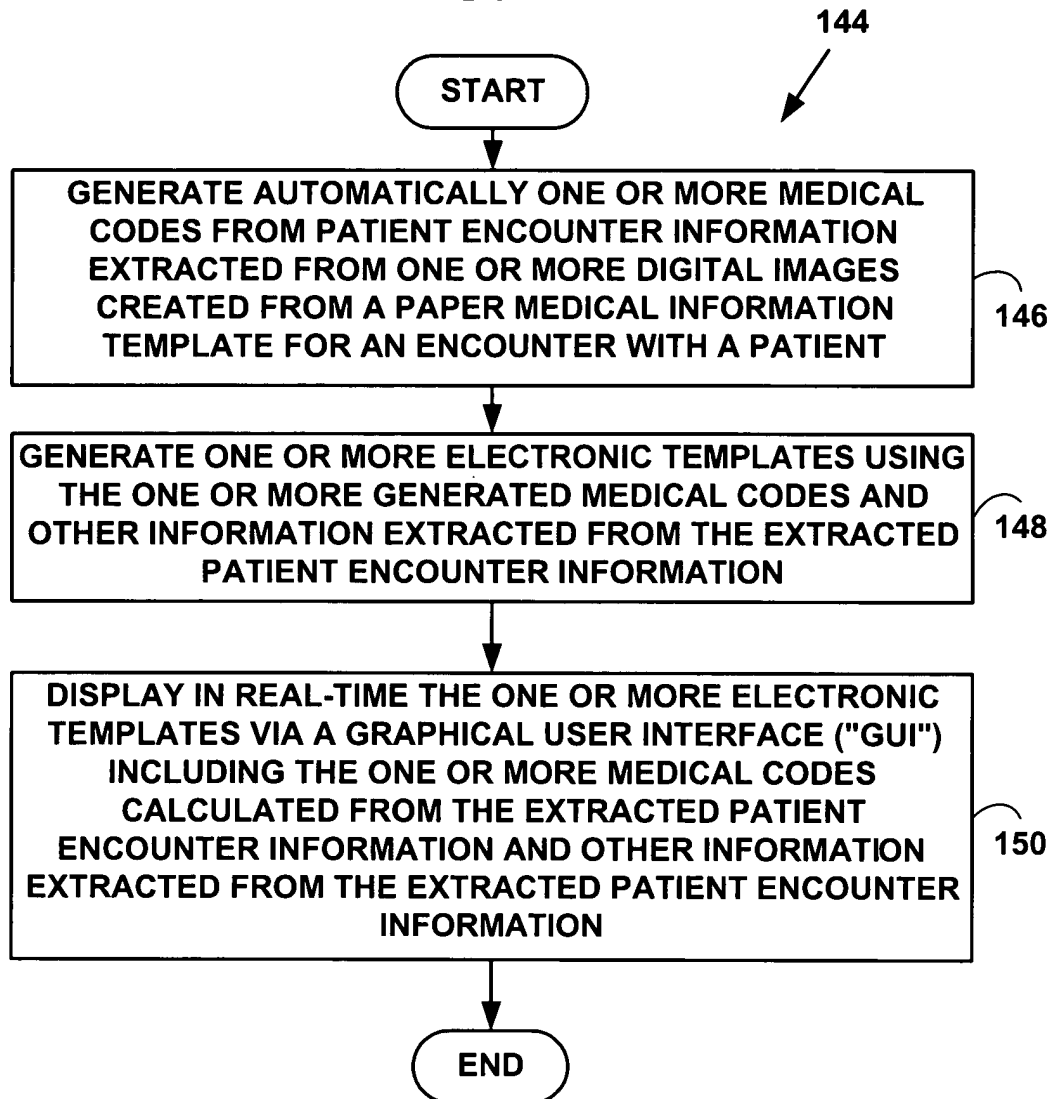
132

	99212	99213	99214	99215
HX	PF	EXPF	DET	COMP
PX	PF	EXPF	DET	COMP
CX	SF	LOW	MOD	HIGH

**FIG. 13**



**FIG. 14**



# FIG. 15

